Testimony to the Special Commission on Health Care Payment Reform established under Chapter 305 of the Acts of 2008
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Presented at the Hearing and Submitted by:

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Thank you for this opportunity to provide input on behalf of many of the Commonwealth's safety net hospitals who serve a disproportionate share of low income, racially and ethnically diverse populations in cities known for their poverty and multitude of challenges.

Across this state, hundreds of thousands of African American, Latino, Asian, low income poor whites rely on certain providers for their care. They rely on disproportionate share hospitals - the safety net hospitals. And they are reimbursed much less than other providers.

As anyone who serves this population knows, the care provided in poor urban communities is cost-effective and patient-centered. But it is largely separate and it has become unequal.

At major tertiary hospitals in Massachusetts they readily acquire big ticket, state of the art, cutting edge technology, while poor urban hospitals petition the State for grants to replace lower cost items such as 10 year old ultrasound machines.

These disproportionate share (DSH) hospitals deliver high quality, patient-centered care very cost effectively. To deliver care well and meet the demands of their patients requires that they provide an array of special services at significant additional expense to meet their patients' social and linguistic complexity. Hospitals with high proportions of low income patients must provide a critical

bundle of interpreter, financial counseling, and social services. These add-on services are not reimbursed. Nor are they reflected in current case mix models, but they are a critical element in delivering patient-centered care. We believe these services, which are required to serve patients effectively, should be reflected in DSH hospital reimbursement and in any new payment method.

Beyond that, these hospitals endeavor, to develop and sustain primary care access and access to specialist care to large numbers of patients. But because of the poor relative reimbursement for care paid by Medicaid, and the challenges of the populations they serve, they find they cannot easily compete for medical staff against practices and hospital groups who have greater financial means to reward them.

Under health reform, a commitment was made to improve and "true up" Medicaid rates to cost, and to pay for performance. DSH hospitals who rely on state payments to a much greater extent than other providers in the State, envisioned that this enhancement would provide a much needed improvement in rates. But the current Medicaid payment methodology for the SPAD and PAPE rewards higher case mix, and directed much of the new dollars disproportionately to the major teaching hospitals who have a higher case mix. An analysis of the new monies invested in improving MassHealth rates under reform in 2007 and 2008 shows that the new dollars did not go to providers in proportion to the amount of their care that is paid by Medicaid. Rather, teaching hospitals won a greater share of the new money relative to their dependence on MassHealth. Providers with much less dependence on MassHealth to sustain services, won the

greatest improvement from the hundreds of millions invested in MassHealth rate enhancement under reform.

In 2009, rates for MassHealth declined for the majority of providers, but those most impacted by these rate cuts are the DSH hospitals, some of whom rely on it for 20% to 30% of their gross revenue.

In 2010, more cuts in MassHealth have been included in the Governor's budget, and Medicaid MCO's are being guided to pay rates aligned with the declining MassHealth rates. These cuts will remove tens of millions of dollars from the health care delivery system in the State's poorest communities – hospitals that already operate on the brink. Thus far, the high likelihood that a federal stimulus plan will bring an increase in the State's FMAP has not inspired a re-evaluation of these cuts but we hope that some of this FMAP increase funds health care rate restoration in DSH hospital communities who are already the hardest hit by unemployment, and foreclosures.

Under reform the DSH hospitals saw dramatic change in payments for care to the uninsured, with rates declining from previous year's levels. Overall support from the Health Safety Net Fund was curtailed in several ways. The most significant way was through a change in payment methodology from one based on the ratio of cost to charges to a Medicare-like system that favored major, non-DSH academic medical centers. Medicare rates in the Commonwealth are highest at the academic medical centers, and Medicare is a very good payor for inpatient care. The major academic medical centers in Massachusetts provide considerably more inpatient uninsured care than outpatient care. But the reverse is true for disproportionate share hospitals. They provide much more outpatient care to the

uninsured, because of their interrelationships and partnerships with health centers who count on them for their ancillary care, and also because the uninsured live in poor urban cities they've traditionally relied on emergency rooms, another major outpatient service. Under reform, this HSN Fund that exists to pay for care to the uninsured experienced a wholesale change in its payment methodology and as defined under health reform rewarded major academic medical centers. Fortunately, a provision to adapt the method of payment to the population which allowed for an add-on of 25% to outpatient rates to be put in place by EOHHS and DHCFP under the Patrick Administration to remedy this for DSH hospitals' HSN payments and also for community hospital HSN payments. We hope that this remedy endures and remains in the HSN payment methodology to recognize the shortcomings of this method for the HSN. Further, we would urge any new payment method to consider the population served.

11.9 Million dollars in High Public Payer DSH payments that had historically been paid to the five providers in the state with the highest proportion of care to low income populations which included communities like Brockton, Cambridge and Lawrence saw that funding stripped away in the FY09 budget.

Payments for psych and substance abuse from most providers, but especially by MassHealth have been among the lowest of any service, forcing closures of these essential services and causing a myriad of emergency psych service demands. Addressing these shortfalls in cost reimbursement is crucial under payment system changes.

Payment reform must ensure that public payments better cover costs for hospitals, especially disproportionate share hospitals who are at greater risk due

to their greater dependence. The DSH hospitals' have played a tremendous role in taking care of the growing number of people enrolled in state sponsored programs under reform, and the consequence to them and the populations they serve, of downward pressure on their rates, is taking its toll.

At the negotiating table with health plans they are utterly lacking in market clout. They are the antithesis of the Globe Spotlight focus. Beyond that, they have seen every distinguishing payment support they have ever received from the Commonwealth in recognition of their Disproportionate Share status swept away in the past three years. Under health reform, they have experienced reductions in payments to support care to low income patients.

A John Kingsdale quote in a November 2008 Price WaterhouseCoopers Health Research Institute paper summed up how this happened. He said "it's not about the new money it will cost for coverage, it's about reallocating the dollars we already spend". Scarce state dollars have been reallocated. Overall the safety net hospitals have seen state payment rates decline as enrollment has risen.

These hospitals lack the market clout to cost shift and fare worst in their negotiations with health plans.

Their access to capital is constrained by negative or narrow operating margins. The financial markets view them as risky and charge them higher rates of interest to borrow.

Most do not have in place electronic health records or CPOE. They need to extract "quality" data from medical records. Prospective, declared, longstanding quality measures are preferred. Payment reimbursement models that encourage

adoption of EMR and CPOE through additional resources provided. Funds to support these IT investments are needed to support some of the payment systems contemplated in Chapter 305. Some providers are unable to achieve the level of IT investment required to manage new methods effectively.

Many of the payment methods outlined in Chapter 305 of the Acts of 2008 as alternatives to fee-for-service models would require providers, rather than insurers, to bear the risk for the cost of care. Safety net hospitals cannot assume a higher level of risk, or any additional risk. Blended capitation rates are one example. Global payments and Medical Homes are others. They would require much more reliance and interdependence among physicians and hospitals than currently exists, especially for safety net providers. Poor reimbursement for care paid by public programs makes it difficult to maintain access to primary care and specialty care. Addressing access must be part of the equation. There is a direct correlation between size and EMR adoption, payment incentives are required.

Beyond that, what do we know of the differences and enhanced financial risks of embarking on these new payment methodologies for affluent populations, versus those that are more frequently homeless, requiring interpreter services, marginally employed, or unable to consistently pay their health care premiums in this economy? How differently do low income populations behave than affluent ones?

Some early innovators among our safety net members are working to develop medical home models but this new terrain would require that risk be shared, not solely shifted to doctors and hospitals. Our physicians and hospitals already operate on slim or negative margins. Pushing too much risk on these providers

could result in fewer providers, in communities where no one would risk new capital to serve.

Research shows that despite their lack of resources, the overall quality of safety net care as measured by health outcomes is no different than other providers, and in Massachusetts it seems that holds true as well.

DSH hospitals are among the more cost efficient providers in the State, achieving quality goals under tremendous fiscal constraints, and providing a wide array of patient centered services targeted to the populations they serve. Encouraging these DSH hospitals to thrive and grow, by providing them with improved rates of payment, and by recognizing their DSH status would serve to reduce overall health care costs. It would also correct the growing imbalance of have and have-not hospitals, before we reach the point in this State where we have a system that penalizes the low income and diverse populations by pressuring the providers in their backyard most.

We would urge the Special Payment Commission to ensure that the design for a new payment system consider the capacity and impact on DSH hospitals.